STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Subcommittee:

I am pleased to appear today at the request of the Subcommittee to offer testimony on behalf of the Disabled American Veterans (DAV) related to access to medical care services in the Department of Veterans Affairs (VA) health care system, particularly on access to care in rural areas. I offer this statement on behalf of *The Independent Budget* (IB) for fiscal year 2008, a product of the joint efforts of DAV, Veterans of Foreign Wars of the United States, Paralyzed Veterans of America and AMVETS.

Congress provided VA additional funding in fiscal years 2006 and 2007, for which we are very grateful, but we continue to hear from veterans that their access to VA specialty care is often delayed for months. Likewise, access to VA care in rural areas of the country has been—and continues to be—a challenge for many veterans. We are especially concerned about how VA plans to address rural veterans' needs in the coming years, given reports that 44 percent of all veterans returning from Operations Enduring and Iraqi Freedom (OEF/OIF) reside in rural communities. After serving their country, veterans' health care needs should not be neglected by VA simply because they live in rural or remote areas at a distance from major VA health care facilities.

Without question, sections 212 and 213 of Public Law 109-461, signed into law by the President on December 22, 2006, represent the most significant advances to date to address health care needs of veterans living in rural areas. Under this legislation, the VA is mandated to establish an Office of Rural Health within the Veterans Health Administration (VHA). This office must carry out a series of steps intended by Congress to improve VA health care for veterans living in rural and remote areas. This legislation is also aimed importantly at better addressing the needs of returning veterans who have served in OEF/OIF. Among its features the law requires VA to conduct an extensive outreach program for veterans who reside in these communities. In that connection VA is required to collaborate with employers, State agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and the National Guard, to ensure that returning veterans and Guard members, once completing their deployments, can have ready access to adequate VA health care. The legislation also requires an extensive assessment of the existing VA fee-basis system of private health care, and eventual development of a VA plan to improve access and quality of care for enrolled veterans who live in rural areas.

Rural veterans, veterans service organizations and other experts need a seat at the table to help VA consider important program and policy decisions such as those being discussed here that would positively affect veterans who live in rural areas. The final legislative language of Public Law 109-461 failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans, and other rural experts, to recommend policies to meet the challenges of veterans' rural health care. We hope that Congress will reconsider this mandate, but the VA Secretary retains the authority to establish such an advisory committee without specific statutory authorization. The *IBVSOs* urge the Secretary to take this action, and to include representatives of our organizations in the membership of that committee.

Although the authors of the *Independent Budget* acknowledge this legislative measure will be beneficial to veterans living in rural and remote areas, the legislation also raises potential concerns about the unintended consequences it may have on the mainstream VA health care system. In general, current law places limits on VA's ability to contract for private health care services to instances which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when existence of a medical emergency prevents a veteran from receiving care from a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services of certain scarce medical specialists. Beyond these limits, there is no general authority in law to support broad-based contracting for the care of populations of veterans, whether rural or urban. The authors of the *IB* believe VA contract care for eligible veterans should be used judiciously and only in circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a critical mass of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, brain and spinal cord injury, or chronic mental health problems. Putting additional budget pressure on this specialized system of services, without making specific appropriations available for new rural VA health care programs, could only exacerbate the problems currently encountered.

The VA has had continuing difficulty securing sufficient funding through the Congressional discretionary budget and appropriations process to ensure basic and adequate access for the care of sick and disabled veterans. Congress repeatedly has been forced to provide additional funds to maintain VA health care services. Also, VA receives no Congressional appropriation dedicated to support the establishment of rural community-based outpatient clinics or to aid facilities VA designated as "Veterans Rural Access Hospitals" (VRAH), and thus VA must manage any additional expenses from within generally available Medical Services appropriations. VA has established and is operating 717 community based outpatient clinics (CBOCs) as sources of primary care. VA considers 320 of these clinics to be in rural or "highly rural" areas. Given current financial circumstances within VA health care, we are skeptical that VA can continue to cost-effectively establish additional facilities in areas with even sparser veteran populations.

Rural Hospitals

Under the federal Medicare program, a "Critical Access Hospital" (CAH) is a private hospital that is certified to receive cost-based reimbursements from Medicare. The higher reimbursements that CAHs receive under this program compared to urban facilities are intended to improve their financial security and thereby reduce rural hospital closures. In other words, the Centers for Medicare and Medicaid Services (CMS) policy is to financially aid struggling rural hospitals in hopes that the additional support can help them survive. Also the CAH facilities are certified under Medicare "conditions of participation" that are more flexible than those used for other acute care hospitals. As of March 2006 (the latest data available), there were 1,279 certified CAH facilities in rural and remote areas.

As a part of the VA's Capital Assets for Enhanced Services (CARES) initiative, the VA employed Medicare's CAH model as a guide to establish a new VA policy to govern operations of, and planning for, many of VA's rural and remote facilities, now designated VRAH. In 2004, however, the CARES Advisory Commission questioned whether VA's policy was adequate and recommended VA "…establish a clear definition and clear policy on the CAH [now VRAH] designation prior to making decisions on the use of this designation."

Following this guidance from the CARES Commission, on October 29, 2004, VA issued a directive that is still in force setting a significant number of parameters for VRAH designations, but that directive seems pointed in the opposite direction from that of Medicare for the CAH facilities in the rural private sector. Illustrative of our concern is the basic definition of VRAH, as follows:

> "A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to health care is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the rural facility. The facility should be part of a system of primary health care (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing access to timely, appropriate, and cost-effective health care for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc." (VHA Directive 2004-061, October 29, 2004)

We believe VA must carefully monitor the scope and quality of services performed at its smaller, rural facilities, specifically for those procedures that are complex in nature. Further, as medical care advances in the use of high technology and thereby elevates the standard of care, small VA inpatient facilities may find it increasingly difficult to effectively maintain, and actually use these new tools, to provide health care at its most sophisticated levels. However, we believe VA must maintain a safe and high quality health care service within each of its facilities,

and to the greatest degree possible offer a comprehensive health benefit to veterans at each of its facilities, whether rural, suburban or urban.

The *IBVSOs* remain concerned about whether VA's VRAH policy fully considers the implications of large-scale referrals from rural VA medical centers in continuing to provide high quality health care in those locations, particularly when veterans are referred to other far off medical centers within a Veterans Integrated Service Network (VISN), or to private facilities. VA must also consider patient satisfaction, continuity of care, family separation and travel burdens in the criteria they use for determining which rural facilities should retain acute care services. If acute care beds are to be retained in one facility because of distances that veterans must travel to access inpatient care or receive specialized services, we believe this logic should be standardized and used system-wide to the greatest extent possible.

Community Based Outpatient Clinics

The new legislation discussed above holds VA accountable for improving access for rural veterans through CBOCs and other access points by requiring VA to develop and implement a plan for improving veterans' access to care in rural areas. The May 2004 Secretary's CARES decision identified 156 priority CBOCs and new sites of care nationwide. The VA Secretary is also required to develop a plan for meeting the long-term and mental health care needs of rural veterans. We urge Congress to include specific funding in fiscal year 2008 to address at least some of these needs in rural areas without eroding VA's Medical Services appropriation.

Workforce

Health worker shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report (National Academy of Science, Institute of Medicine, Committee on the Future of Rural Health Care, 2005) recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deeper involvement in health professions education of future rural clinical providers seems essential in improving these situations in VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities each year. In addition, more than 32,000 associated health science students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their personnel needs.

Beneficiary Travel Program

Another component of making sure that veterans get access to the care they need relates to the VA beneficiary travel program. This program is intended by Congress to assist veterans in need of VA health care to gain access to that care. As you are aware, the mileage reimbursement rate is currently fixed at eleven cents per mile, but actual reimbursement is limited by law with a

$3.00 per trip deductible capped at $18.00 per month. The mileage reimbursement rate has not been changed in almost 30 years, even though the VA Secretary is delegated authority by Congress to make rate changes when warranted. The law also requires the Secretary to make periodic assessments of the need to authorize changes to that rate. Unfortunately, no Secretary has acted to make those changes, despite the obvious need to update the rate of reimbursement to reflect rises in travel and transportation costs.

In 1987, the DAV, in coordination with VA's Voluntary Service program, began buying and donating vans to VA for the purpose of transporting veterans for outpatient care. Since that time, the DAV National Transportation Network has become a very significant and successful partnership between VA and DAV. We have donated almost 1,800 vans to VA facilities at a cost exceeding $20 million. These vans and their DAV volunteer drivers and medical center volunteer transportation coordinators have transported nearly 520,000 veterans over 388 million miles. We plan to continue and enhance this program, not only because the VA beneficiary travel rate is so low, but also we have found our transportation network serves as a truly vital link between rural veterans and crucial VA health care. Its absence would equate to the actual denial of care for eligible veterans because many of them have no means to substitute.

DAV, along with several others, has a long-standing resolution (DAV Resolution 212) supporting repeal of the beneficiary travel pay deductible for service-connected veterans and to increase travel reimbursement rates for all veterans who are eligible for reimbursement. Additionally, we support legislation that has been introduced in Congress to repeal the mandatory deductible and increase the rate veterans are reimbursed for their authorized travel to and from VA services. We believe H.R. 963 (introduced by Mr. Stupak); H.R. 1472 (introduced by Mr. Barrow, with Mr. Baca, Mr. Burton of Indiana, Mr. Boswell, Ms. Bordallo, Mr. Boucher, Mr. Abercrombie, Mr. Boren and Mr. Courtney); and; S. 994 (introduced by Senator Tester and Senator Salazar), all termed the "Veterans Travel Fairness Act," offer a fair and equitable resolution to this dilemma about which we have been concerned for many years. We urge this Committee and your Senate counterpart to approve and enact legislation this year to reform the VA beneficiary travel program. Given the cost of transportation in 2007, including record-setting gasoline prices, a reimbursement rate unchanged since 1977 pales in comparison to the actual cost of travel.

Mental Health Care

As indicated above, given that 44 percent of newly returning veterans from OEF/OIF live in rural areas the *IBVSOs* believe that they too should have access to specialized services offered at VA's Readjustment Counseling Service's *Vet Centers.*

Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling for military-related trauma. Building on the strength of the *Vet Centers* program, VA should be required to establish a pilot program for mobile *Vet Centers* that could better outreach to veterans in rural and remote areas.

Homelessness

Helping homeless veterans in rural and remote locations recover, rehabilitate, and reintegrate into society is complex and challenging. VA has no specific programs to help community providers who focus on rural homeless veterans. The rural homeless also deserve attention from VA to aid in their recoveries. Likewise, Native American, Native Hawaiian, and Native Alaskan veterans have unique health care needs that VA needs to address with additional outreach and other activities.

Mr. Chairman, thank you for the opportunity to provide testimony on these very important issues related to access to VA health care services. In *The Independent Budget* for fiscal year 2008, our organizations made a number of recommendations to Congress and VA that are relevant to the issues discussed today in this testimony. We invite you to review these recommendations, reprinted below.

Recommendations:

VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reductions in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

VA must ensure that the distance veterans travel as well as other hardships they face be considered in VA's policies in determining the appropriate location and setting for providing VA health care services.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee, to include membership by the veterans service organizations.

VA rural outreach should include a special focus on Native American, Native Hawaiian, and Alaska Native veterans' unmet health care needs.

Through its affiliations with health professions schools, VA should develop a policy to help supply health-professions clinical personnel to rural VA facilities and to rural areas in general.

Mobile *Vet Centers* should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and remote areas.

VA must focus some of its homeless veteran program resources, including contracts with, and grants to, community-based organizations, to address the needs of homeless veterans in rural and remote areas.